

Montana Adult Tobacco Survey 2006

Montana Tobacco Use Prevention Program
Department of Public Health and Human Services

August 2007



Montana Adult Tobacco Survey 2006

August 2007

Analysis by
Carol Ballew, PhD
Tobacco Use Prevention Program
Department of Public Health and Human Services
1400 Broadway, Room C317
Helena, MT 59620
405-444-9617
<http://www.tobaccofree.mt.gov>



The Montana Adult Tobacco Survey 2006

Highlights

The Adult Tobacco Survey (ATS) is conducted in 17 states under a cooperative agreement with the Centers for Disease Control and Prevention (CDC). Montana conducted the survey in 2004, 2005, and 2006.

In 2006, 2437 adult Montanans chosen at random to represent all residents of the state participated in the telephone survey. They answered questions about their tobacco use, efforts to quit, exposure to second-hand smoke, and opinions about tobacco-related public policies.

- 17% of Montana adults are smokers.
- Smokers want to quit:
 - ✓ 66% of smokers say they want to quit.
 - ✓ 49% of smokers have tried to quit in the past year.
 - ✓ 62% of smokers are considering quitting in the next six months.
- 12% of Montana men are current spit tobacco users.
- Spit tobacco users want to quit:
 - ✓ 47% of spit tobacco users say they want to quit.
 - ✓ 48 % of spit tobacco users are considering quitting in the next six months.
- 60% of smokers were advised to quit by a health care professional.
- Only one quarter of smokers were offered substantive assistance to quit by a health care professional.
- Smokers who have tried to quit underutilize aids to quitting such as Nicotine Replacement Therapy, classes and counseling, and telephone QuitLines.
- 81% of smokers are aware of assistance to quitting, but fewer than half anticipate using assistance in their next quit attempt.
- 83% of Montanans support smoking prohibitions in indoor concerts and sports events.
- 84% support the Montana Clean Indoor Air Act now in place for restaurants.
- 67% support the Clean Indoor Air Act as it will be extended to bars, taverns, and casinos in October 2009.
- 85% believe it is important for bar workers to have a smoke-free workplace.
- 66% would support additional cigarette tax.

Table of Contents

Introduction	6
Results	12
Section I. Characteristics of the Sample	13
Section II. Prevalence of Tobacco Use	15
Section III. Tobacco Cessation	17
Section IV. Knowledge of Health Risks	20
Section V. Home Environment	23
Section VI. Work Environment	25
Section VII. Public Policy	26
Section VIII. Tobacco Purchasing Patterns.....	33
Summary and Recommendations	34
Appendices	
1. Data Tables	38
2. Questionnaire.....	64

INTRODUCTION

All states in the United States have had tobacco control and prevention programs since 1996 and some started much earlier. These efforts are funded in part by the Centers for Disease Control and Prevention (CDC) through cooperative agreements with the states. As part of the agreements, states must evaluate progress in tobacco prevention, cessation, exposure to second-hand smoke, and community attitudes and values surrounding tobacco use. Montana was part of the national Master Settlement Agreement of 1998 that awarded payments to states from the tobacco companies. In 2000, the Montana Department of Public Health and Human Services and the Governor's Advisory Council on Tobacco Use Prevention published a five-year plan to be funded in part by Montana's tobacco settlement funds. In 2004, the plan was extended through 2010. It is essential to monitor the progress of the plan and to evaluate the efficacy of programs using state and federal tobacco prevention funds. Population-based surveys are the only way to obtain accurate and representative data about the residents of a state.

The Montana Adult Tobacco Survey (ATS) is designed to produce statewide representative information on tobacco use, and knowledge and attitudes about tobacco. Montana is one of 17 states that conduct an ATS in collaboration with the CDC. The core questionnaire is standardized for all states so data can be compared across states and can be combined to create national estimates. Individual states may include optional questions supplied by the CDC or they may include state-generated questions about topics of local interest.

The Population

The survey represents non-institutionalized adults (18 years and older) living in residences with landline telephones. The survey excludes adults living in group quarters such as barracks, boarding houses, convents, dormitories, mental institutions, nursing homes, prisons, or shelters. According to the 2000 Census, approximately 3% of the Montana population lived in group quarters.¹ The survey excludes adults who are not usual residents of the location where they are contacted. It excludes individuals who do not speak English. Finally, it excludes individuals who live in residences without landline telephones. According to the 2000 Census, fewer than 3% of Montana households did not have telephones, although the Census question does not clearly differentiate between landline and cell phone availability.

The sample excludes individuals who have only cell phone service. Nationally, approximately 8% of households do not have landline telephones but have one or more cell phones.² The national survey found renters (20%) were more likely than homeowners (4%) to have only cell phone service, households below the poverty level

¹ Montana Department of Commerce, Economic and Demographic Analysis of Montana, Volume II, Demographic Analysis. Center for Applied Economic Research, Montana State University, Billings, December 2004.

² <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/wireless/wireless2006.htm>

(14%) were more likely than higher-income households to have only cell phone service, and adults age 18-24 (18%) were more likely than older adults to have only cell phone service. Adults living in households with unrelated roommates were the most likely group to have only cell phone service (34%). These sociodemographic differences among cell phone and landline users have implications for our ability to reach some groups of potential participants.³

The Sample

The sample was selected by random-digit dialing (RDD) from lists of all working landline telephone numbers, a list that includes new and unlisted numbers. The Montana sample was designed to include regions with high and low population densities (i.e., urban and rural/frontier) and a region with a relatively high proportion of American Indian residents. To achieve this, there were three geographic strata: counties with high general population and low American Indian population; counties with low general population but high American Indian population; and counties with both low general and low American Indian populations.

Each randomly selected phone number was called up to 15 times or until

- It was determined not to be a working number,
- It was persistently busy,
- It was determined not to be a residential number,
- No eligible adult participant was identified or available,
- An eligible adult was not able to complete the interview,
- A definitive refusal was received, or
- An interview was completed.

Once an eligible household was identified, the interviewer followed a strict protocol to select an adult to be interviewed. The goal of the selection process was to ensure that the characteristics of the people interviewed represent those of the population of the state as closely as possible in terms of age, sex, and race.

The response rate for the 2006 ATS survey, calculated as the number of participants who completed the interview divided by the number of calls in which the interviewer identified an eligible participant, was 65%. This is a modest rate for telephone surveys and less than the goal of 70% generally accepted as providing reliable survey data.⁴

³ Blumberg et al., 2006, *Am J Public Health* 96:926-931.

⁴ Massey et al., 1997. Response rates in random digit dialing (RDD) telephone surveys. *Proc Survey Meth Research Sect, Am Stat Assn* 1997:707-712.

Does the Sample Represent the Population of the State?

The sampling and statistical weighting procedures were designed to yield a group of participants that resembled state residents closely in terms of sex, age, and race. Correspondence between the *weighted* sample and the state as a whole for these characteristics was very close. The sample had more married participants and more participants with children in the home, and participants with more education and income than state residents as a whole. Many surveys find that individuals with higher education are more likely to participate. Given the strong correlation between education and income in the sample, higher educational attainment probably accounts for the higher income of participants as well. In addition, many married adults live in two-income households. Because tobacco use and attitudes about tobacco vary by many sociodemographic factors including education and income, the analysis was adjusted by these factors.

	<u>Weighted ATS 2006</u>	<u>Statewide⁵</u>
Male	49%	50%
Age		
18-24	14%	12%
25-34	15%	13%
35-54	38%	36%
55-74	15%	23%
75+	18%	16%
Race		
White	91%	91%
American Indian	6%	7%
All Other	3%	2%
Married	67%	57%
Children in the home ⁶	40%	33%
Education		
Less than college graduate	63%	78%
College graduate or more education	37%	22%
Household Income		
Below state median	46%	50%
Above state median	54%	50%

⁵ <http://ceic.commerce.state.mt.us/Publications/MTBYNUMB.PDF> ;
http://commerce.mt.gov/housing/Indulcdes?CP/word/CP_ED_vol_I.doc

⁶ Age 17 years or younger

Quality Assurance

The core and optional questions supplied by the CDC have been developed and validated over a number of years. States may add questions selected from a menu of previously validated questions or may create their own by consulting with subject matter experts and questionnaire design experts. Montana added only two questions that had not been previously validated; these questions were pre-tested in 50 interviews.

Montana contracts with ORC Macro of Burlington, Vermont to conduct the ATS telephone interviews. ORC Macro also provides this service to the Montana Behavioral Risk Factor Surveillance System (BRFSS) survey and to 21 other states conducting the ATS, the BRFSS, or both. They have a staff of experienced telephone interviewers supported by an extensive technologic system, the computer-assisted telephone interviewing system (CATI), which helps interviewers follow a complicated protocol in a consistent way. CATI guides interviewers through contact attempts and participant selection, follows skip patterns in the questionnaire, and flags invalid responses. Interviewers receive extensive training on the questionnaire itself and on interaction with participants. They are trained to read every question verbatim, to be neutral and non-judgmental, and not to lead or influence participants' answers.

Limitations of the Data

The cost of conducting the ATS is substantial. Much of the cost is due to the number of calls that must be made because only a small percent resulted in completed interviews. The cost and low efficiency of the RDD method limits the sample size that we can ultimately obtain. In 2006, there were 2437 participants. The sample size restricts the complexity of the analysis we are able to do, especially because there were only 356 current smokers and 131 current spit tobacco users in the sample. In spite of including a geographic stratum with a relatively large American Indian population, there were only 161 American Indians in the sample.

Analysis based on cell sizes less than 20 participants is potentially unreliable.⁷ A cell is a category created by subdividing the sample into groups using one or more characteristics. For example, if we compare the prevalence of smoking among men and women, male smokers are one cell, female smokers are another cell, and so on. If we were to subdivide smokers by sex, race, and education, we would end up with many small cells and possibly empty cells. Statistical analysis based on one or more small cells is likely to be unreliable; analysis based on one or more empty cells is generally considered inappropriate. In addition to creating technical problems for statistical analysis, small cell sizes raise the possibility of loss of confidentiality. Most surveys have a criterion for not reporting information about participants in small cells. We have not reported on cell sizes less than 20 in the charts and data tables in this report.

⁷ Analytic and reporting guidelines: The Third National Health and Nutrition Examination Survey, NHANES III (1988-94) October, 1996 National Center for Health Statistics Centers for Disease Control and Prevention, Hyattsville, Maryland .

Cell size can sometimes be improved by collapsing several small categories into fewer, larger categories. While this may yield adequate cell sizes for analysis, it may also hide important differences among the groups collapsed. It is therefore important to choose cutpoints to define categories that are both meaningful and divide the sample into approximately balanced numbers. We have used this strategy with annual household income, originally classified into eight categories. After evaluating the distribution of the participants' incomes, and the association between income and other characteristics, we determined that two income categories (above and below the state median) would be appropriate. Education was collapsed from 11 categories to three. We constructed five age categories.

Data Analysis and Interpretation

Weights and Strata

Each participant in the survey had a probability of being selected. That probability was determined by the size and composition (age, sex, race) of the population in the geographic region (stratum) where the person lived. The probability was used to assign a sample weight for each participant to reflect the fact that he or she represents a large number of similar people. In addition, each participant was assigned a stratum code to reflect one of the three geographic regions of the state used in the sampling protocol. The weight and stratum codes were used in the statistical analysis to create estimates of the prevalence of smoking and other characteristics in the population of Montana as a whole, based on the answers from the participants in the survey.

Because of the use of sample weights and stratum codes, the estimated population prevalences for items in the survey differ slightly from the actual numbers that would be calculated based only on the participants' unweighted answers. For example, there were 2437 participants, 41% male and 59% female. The weighted sex distribution for the sample was 49% male and 51% female, very similar to the 2006 population projections from the Census Bureau. Ninety percent of the participants identified themselves as white and 7% identified themselves as American Indian. The corresponding weighted survey distribution was 91% white and 6% American Indian. The 2000 Census proportions were 92% and 7%, respectively. The remaining participants are of all other races.

Statistical Analysis

Tobacco use and attitudes about tobacco vary by many factors, including sex, age, race, education, and income. We used multivariate analysis to examine the effects of each factor on the endpoints reported here, controlling for the simultaneous effects of all other factors. Because the endpoints were discrete (e.g., smoker/non-smoker, approve/disapprove of public policy), we used multiple logistic regression analysis. Each reported point estimate is therefore adjusted for possible confounding effects. For example, white participants in the sample were on average older and had more

education and income than American Indian participants. Adjusting for these differences by multiple logistic regression, the differences between white and American Indian participants were generally not statistically significant, except as noted in the charts and tables. All analyses were performed with SAS-callable SUDAAN⁸ which accommodates the weighting and stratification of the data.

Comparisons with Other Data Sources

The other population-based source of data on adult smoking prevalence in Montana is the Behavioral Risk Factor Surveillance System (BRFSS). Like the ATS, the BRFSS is conducted annually. It includes two questions about smoking that allow participants to be classified as current smokers, former smokers, and those who have never smoked. These questions are identical to two questions in the ATS. The BRFSS is conducted the same way as the ATS, as an anonymous RDD telephone interview with three geographic strata, intended to produce a representative sample of the adult population of the state, so we expect the results to be similar to those of the ATS.

Because both the ATS and the BRFSS are based on samples of the population, the population prevalence estimates have associated uncertainties, expressed by the Confidence Intervals around the estimates. Even if the estimated prevalence of smoking differs between the ATS and the BRFSS, if the Confidence Intervals overlap, the estimates are not considered statistically significantly different.

The 2006 ATS estimated that 16.7% of Montana adults are current smokers, with a Confidence Interval of 14.3% to 19.1%. The 2006 BRFSS estimated smoking prevalence at 18.9% with a Confidence Interval of 17.5% to 20.3%.⁹ The Confidence Intervals overlap so the point estimates of cigarette smoking are not considered statistically different.

⁸ SAS release 8, SAS Institute Inc., Cary, NC; SUDAAN release 9, Research Triangle Institute, Research Triangle Park, NC.

⁹ <http://apps.nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2006&qkey=4396&state=MT>

Results of the 2006 Adult Tobacco Survey

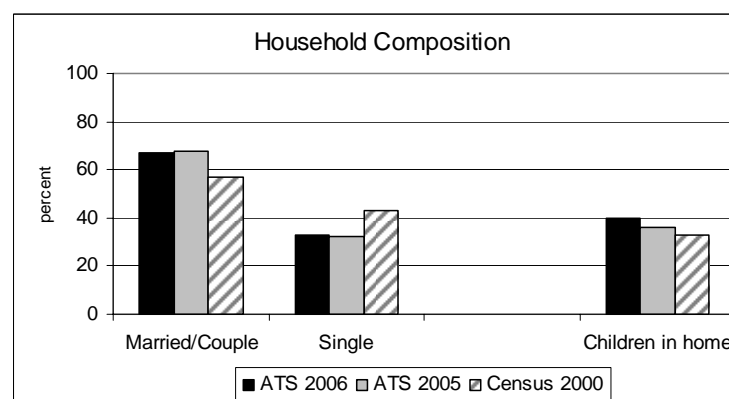
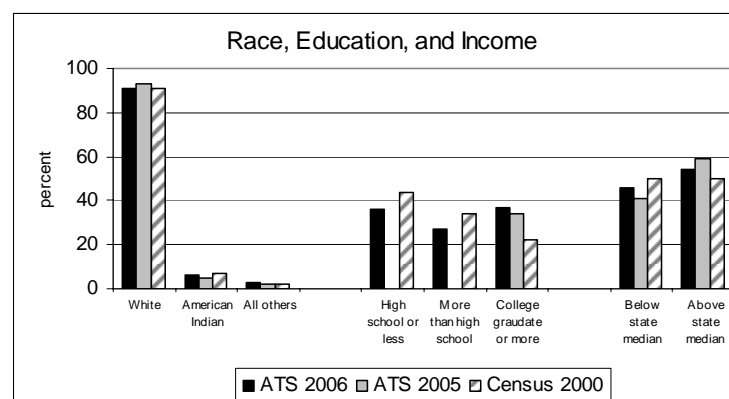
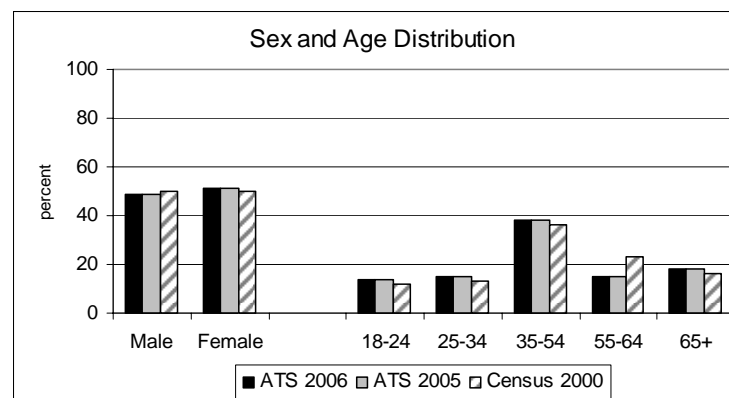
Section I Characteristics of the Sample

The 2006 Adult Tobacco Survey was designed to be representative of the population of the state of Montana in terms of sex, age, and race distributions. Sample weights were assigned to achieve this representation. As a result, the sex, age, and race distributions, *based on sample weights*, closely approximates that of the state population.

The sample was not stratified or weighted by other sociodemographic characteristics, but comparing the sample to the state population in the 2000 Census shows a reasonable correspondence. The 2006 ATS participants had slightly more education and slightly greater income than residents of the state as a whole, as did participants in the 2005 ATS. Education and income were highly positively correlated in the ATS samples.

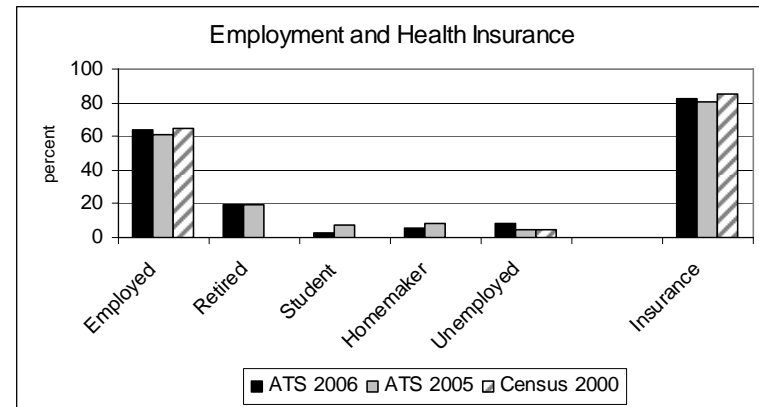
The majority (67%) of participants in the 2006 ATS were married or otherwise part of a couple. The remaining 33% were divorced, widowed, separated, or never married. These proportions are similar to those of participants in the 2005 ATS. More state residents were single (43%) in the 2000 Census.

Forty percent of the participants in the 2006 ATS had children age 17 or younger living in their households, slightly higher than 36% for participants in the ATS 2005 and higher than 33% for state residents in the 2000 Census.



Sixty-four percent of 2006 ATS participants were employed, compared to 61% of 2005 ATS participants and 65% of state residents in the 2000 Census. Unemployment was slightly lower in the 2000 Census (5%) than among 2006 ATS participants (8%). Three percent of 2006 ATS participants were students, 6% were homemakers, and 19% were retired. Comparable proportions are not available from the 2000 Census.

Eighty-two percent of participants in the 2006 ATS had health insurance, excluding Medicare or Medicaid, compared to 85% of residents in the 2000 Census.



Section II Prevalence of Tobacco Use

Smoking Cigarettes

Overall, 17% of the ATS 2006 participants were current smokers, compared to 18% in 2005.

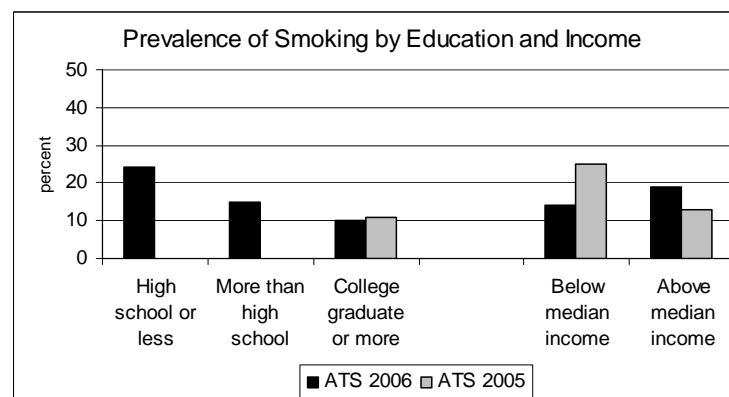
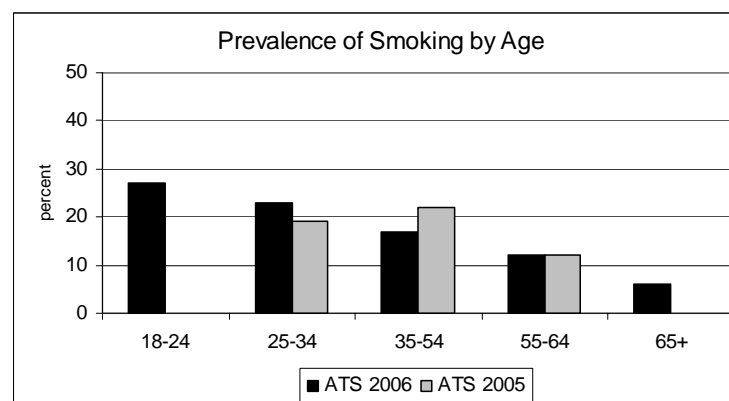
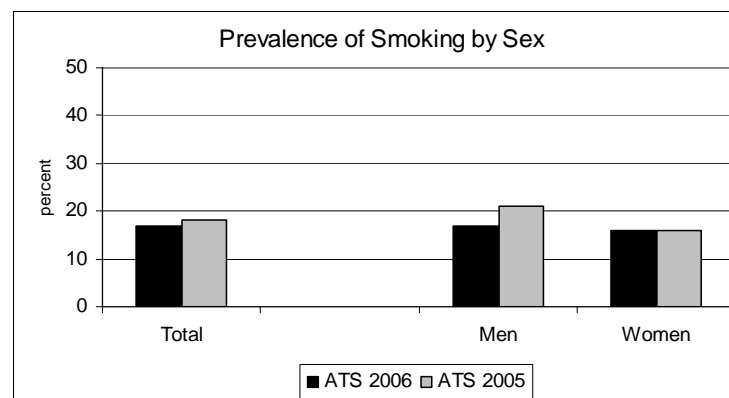
Slightly more men (17%) than women (16%) were current smokers in 2006. Although 21% of men were smokers in 2005, the difference between 2005 and 2006 was not statistically significant.

Smoking decreased with increasing age group ($p < .05$). Smoking was most prevalent among participants age 18 to 24 (27%) and 25 to 34 (23%). Smoking was very uncommon among participants age 65 and older (6%).

Smoking was more common among participants with a high school education or less (24%) than among those with some post-high school education (15%) or those with a four-year college degree or more education (10%).

Among participants with a high school education or less, smoking decreased from 25% in the 2005 ATS to 14% in the 2006 ATS ($p < .05$).

Missing columns represent fewer than 20 responses.



Spit Tobacco Use

Overall, 6% of participants classified themselves as current spit tobacco users in the 2006 ATS, compared to 7% in 2005. This is deceptive because 12% of men but very few women used spit tobacco, compared to 13% of men in 2005.

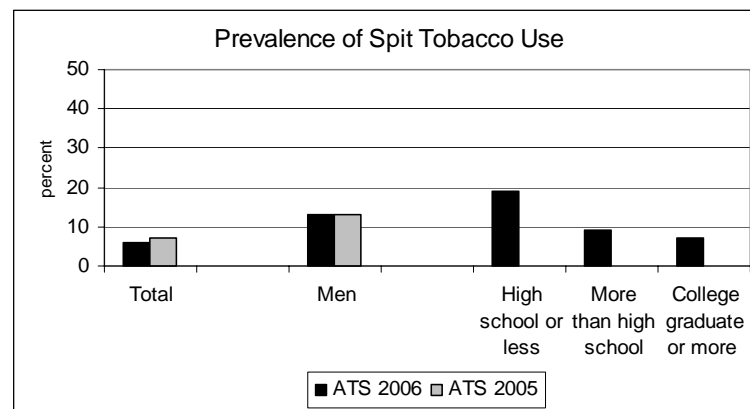
There were too few spit tobacco users to conduct an analysis by age group.

Spit tobacco use was highest among men with a high school education or less (17%) relative to those with more education (9% and 7%, respectively), but this difference was not statistically significant.

There were too few spit tobacco users to conduct analyses by income or race.

Cigars and Pipes

Only 3% of the sample overall and 9% of men reported smoking cigars and only 1% of men reported smoking pipes in 2006. Cigarette smokers were more likely than non-cigarette-smokers to smoke cigars (13% and 3%, respectively, $p < .05$; data not shown).



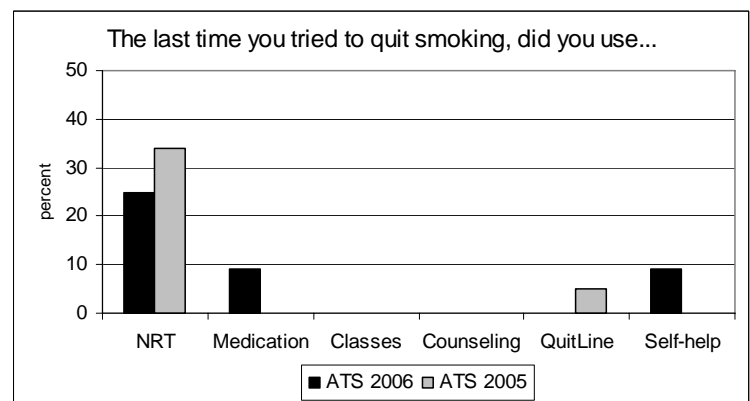
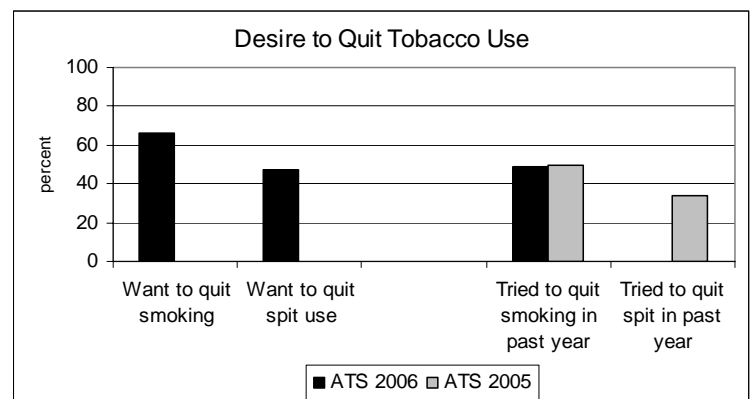
* Missing columns represent fewer than 20 respondents.

Section III Tobacco Cessation

Prior Attempts to Quit

Sixty-six percent of smokers and 47% of men who use spit tobacco wanted to quit. Forty-nine percent of smokers had tried to quit in the past year.

Relatively few smokers had used quitting assistance in their last quit attempt. Only 25% had used Nicotine Replacement Therapy (NRT) in 2006, down from 34% in 2005 ($p < .05$). Only 9% had used additional medication, 9% used self-help materials, and very few used classes, counseling, or a telephone QuitLine.



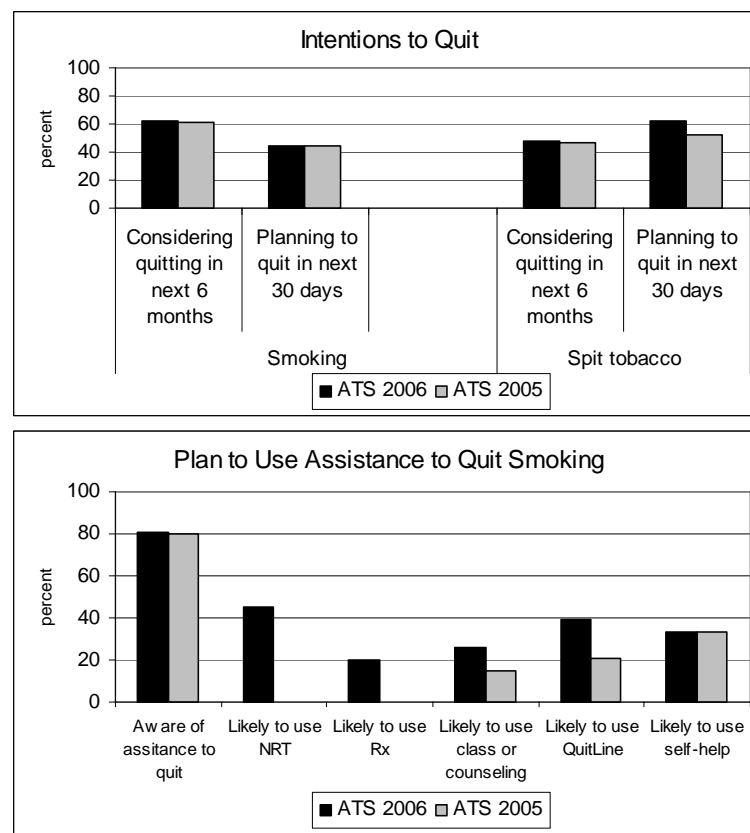
§ Missing columns represent questions not asked.

* Missing columns represent fewer than 20 responses.

Intentions to Quit

In 2006, 62% of smokers and 48% of men who used spit tobacco were considering quitting in the next six months. Forty-five percent of smokers and 62% of men who used spit tobacco were planning to quit in the next 30 days. These proportions are similar to those from 2005.

Most participants (81%) were aware of assistance to quit tobacco use, but relatively few said they were likely to use any form of assistance. Forty-five percent said they were likely to use Nicotine Replacement Therapy (NRT), but only 20% said they were likely to use other medications, 26% said they were likely to use classes or counseling, up from 15% in 2005 ($p < .05$), and 33% said they were likely to use self-help materials. In 2006, 39% said they were likely to use a telephone QuitLine, up from 21% in 2005 ($p < .05$).



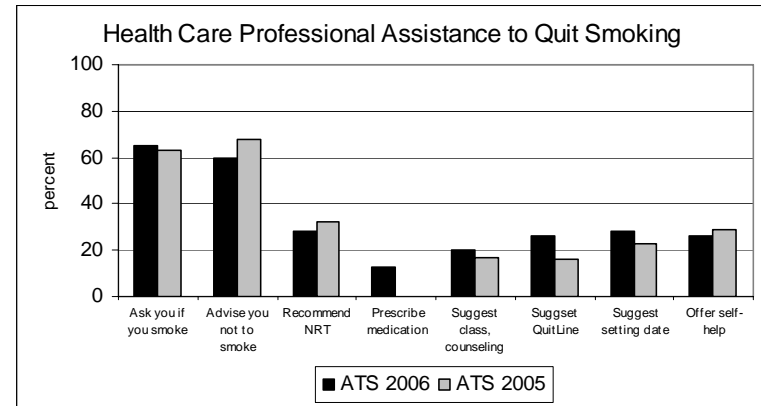
Health Care Professional Assistance

All participants were asked if they had seen a doctor, nurse, or other health care professional to receive any kind of health care in the 12 months before the survey. Seventy-five percent of the total sample, 70% of smokers, and 68% of spit tobacco users had seen a health care professional (data not shown).

Among smokers who had seen a health care professional, 65% reported they had been asked if they smoked and 60% reported they had been advised to quit, but fewer than one third had been offered each form of assistance to quit by a health care professional.

Overall, 69% of participants had seen a dentist in the past 12 months. Sixty-two percent of smokers and 74% of spit tobacco users had seen a dentist (data not shown).

Only 44% of smokers who had seen a dentist reported that their dentist advised them not to smoke. Twenty-three percent said their dentist suggested Nicotine Replacement Therapy (NRT) but very few reported their dentist recommended any other form of assistance to quitting (data not shown).



* Missing columns represent fewer than 20 responses.

Section IV Knowledge of Health Risks

Smoking

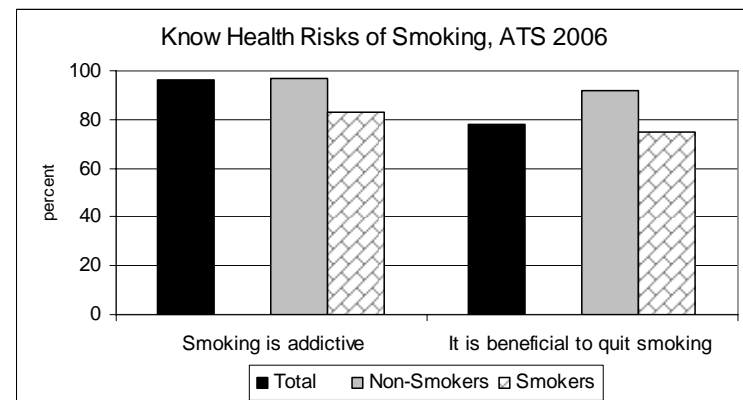
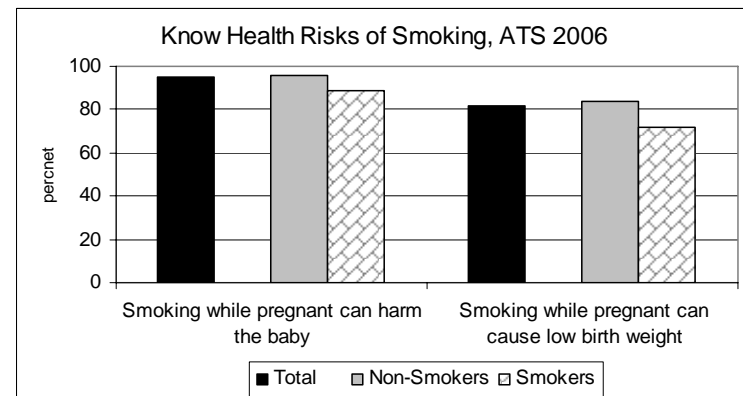
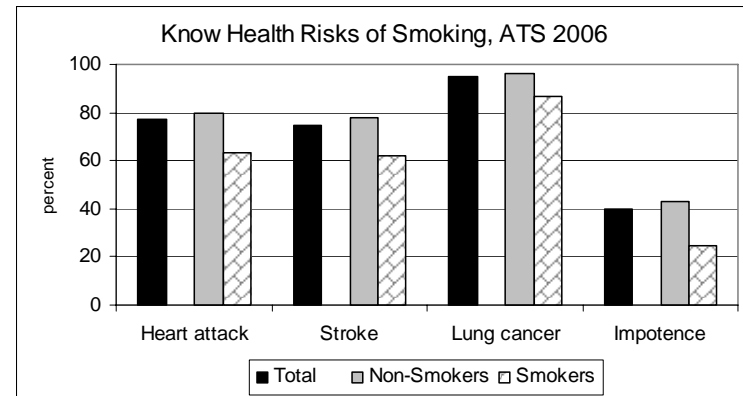
Although 95% of participants believed smoking causes lung cancer, only 77% believed smoking causes heart attacks, only 75% believed smoking causes strokes, and only 40% believed smoking causes impotence.

Overall, 95% of participants believed smoking during pregnancy can harm the baby and 82% believed smoking causes low birth weight.

For all health risks, there were no differences in knowledge by sex, educational attainment, income, or race. More participants age 18 to 34 than older participants, and more women than men, believed smoking while pregnant causes low birth weight ($p < .05$; data not shown). For all health risks, fewer smokers than non-smokers believed smoking is harmful ($p < .05$).

Almost all participants believed smoking is addictive. There were no differences by sex, age group, educational attainment, income, race, or smoking status.

More than three quarters of participants believed it is beneficial for someone to quit smoking after smoking a pack a day for 20 years. This did not differ by smoking status. Participants with a high school education or less were less likely than those with more education to believe in the benefits of quitting ($p < .05$; data not shown).



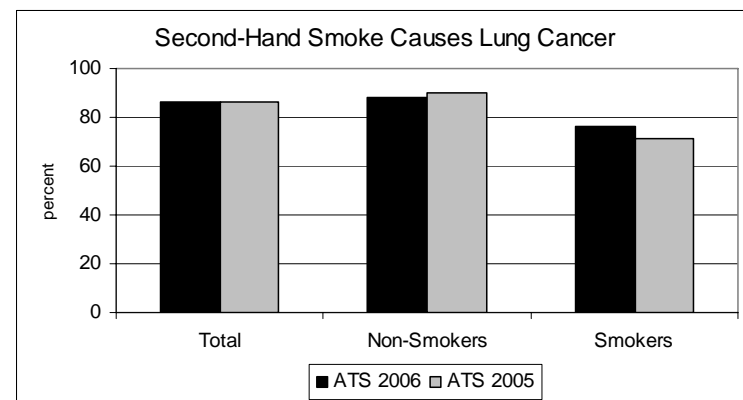
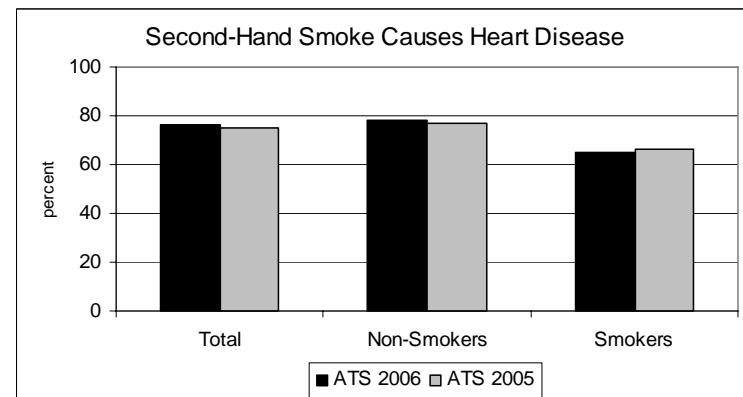
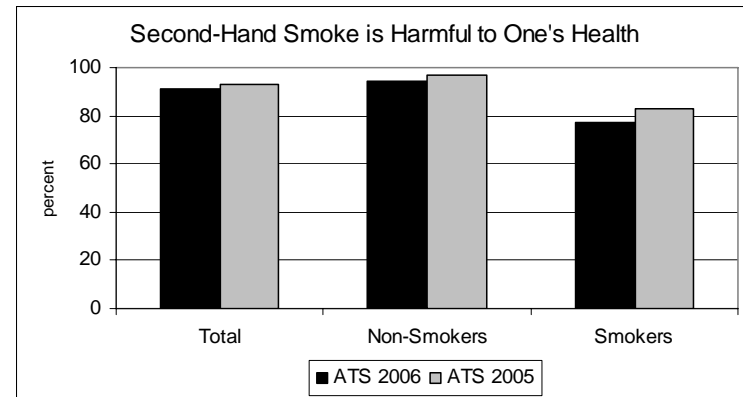
Second-Hand Smoke

Most (91%) of participants believed smoke from other people's cigarettes is harmful to one's health. More women (95%) than men (87%) were aware of the adverse health effects of second-hand smoke ($p < .05$; data not shown). Fewer smokers (77%) than non-smokers (94%) were aware of the adverse health effects of second-hand smoke ($p < .05$).

There were no differences in awareness by age, education, income, or race.

Participants were less aware of the specific adverse health effects of second-hand smoke. In 2006, only 76% believed second-hand smoke causes heart disease. This is similar to the proportion in 2005 (75%), although there was an increase in awareness among men, from 70% in 2005 to 75% in 2006 ($p < .05$; data not shown). Fewer smokers (65%) than non-smokers (78%) believed this ($p < .05$).

Overall, 86% of participants believed second-hand smoke causes lung cancer. There were not differences by sex, age group, education, income, or race. Fewer smokers (76%) than non-smokers (88%) believed this ($p < .05$).

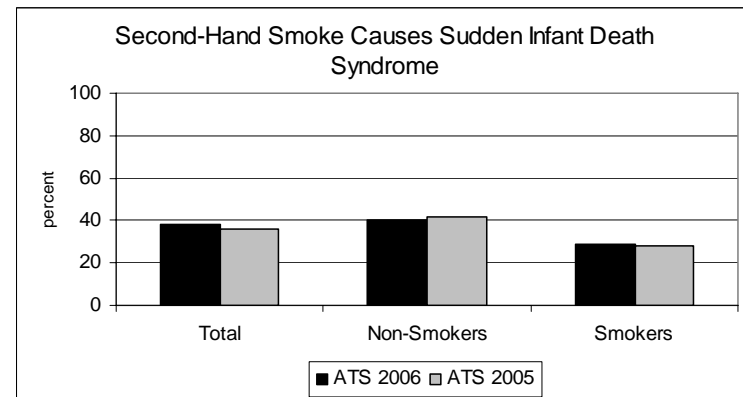
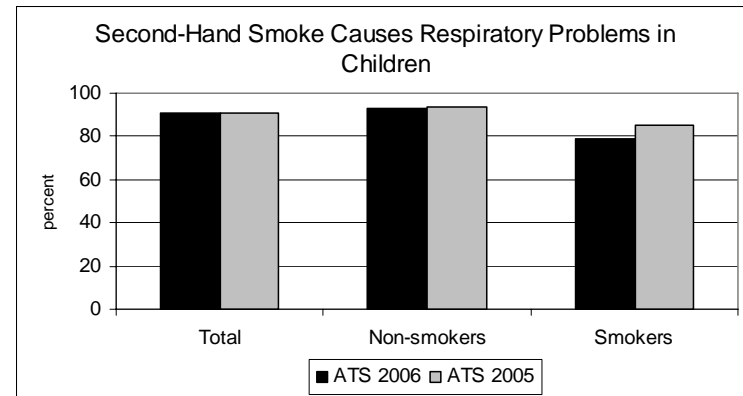


Overall, 91% of participants believed second-hand smoke causes respiratory problems in children. There were no differences by sex, age group, education, income, or race. Fewer smokers (79%) than non-smokers (93%) believed this ($p<.05$).

Although the association between second-hand smoke and Sudden Infant Death Syndrome (SIDS) is well-established and has been the subject of public education campaigns, knowledge about this is low in Montana.

Only 38% of participants in 2006 knew second-hand smoke is a risk factor for SIDS. There was no significant change overall from 2005 (36%) although more men (34%) in 2006 than in 2005 (29%) were aware of the association ($p<.05$).

In 2006, more participants age 18 to 24 (59%) and age 25 to 34 (48%) than older participants were aware of this association ($p<.05$; data not shown). Between 2005 and 2006, awareness increased from 31% to 37% among higher income participants but decreased from 46% to 39% among lower income participants (each $p<.05$; data not shown).



Section V Home Environment

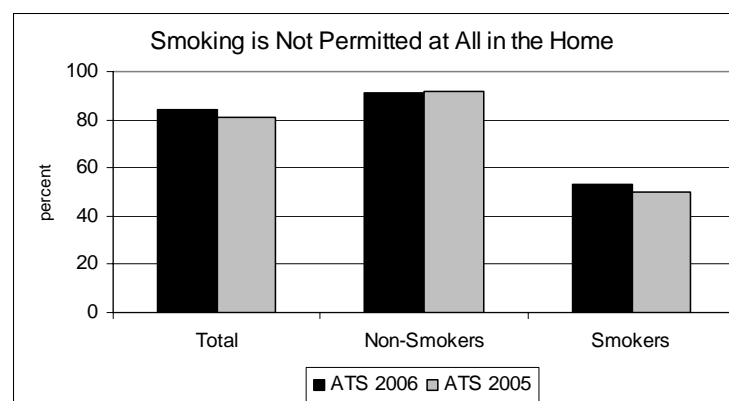
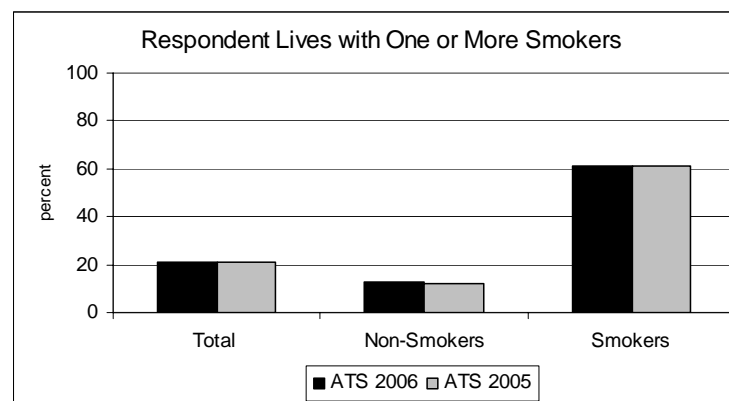
Only 21% of participants lived with other adults who smoked cigarettes, cigars, or pipes. More smokers (61%) than non-smokers (13%) lived with other people who smoked ($p<.01$).

The overall proportion of participants who lived with smokers did not decrease significantly between 2005 and 2006, but it decreased among participants age 35 to 54 (from 24% to 19%, $p<.05$), among participants who were college graduates or more (24% to 18%, $p<.05$), among participants with incomes below the state median (27% to 22%, $p<.05$), among participants with children at home (28% to 21%, $p<.05$), and among participants with no children at home (34% to 22%, $p<.05$) (data not shown).

Overall, 84% of participants did not permit smoking at any time or in any place in their homes. More women (88%) than men (81%) did not permit smoking in their homes ($p<.05$; data not shown). The proportion of participants who did not permit smoking in their homes increased with increasing educational attainment (79%, 84%, and 90%, $p<.05$; data not shown). More non-smokers (91%) than smokers (53%) did not permit smoking in their homes ($p<.01$).

The proportion of participants who did not permit smoking in their homes increased between 2005 and 2006 among women (from 84% to 88%, $p<.05$), among participants age 35 to 54 (80% to 85%, $p<.05$) and age 65 and older (75% to 81%, $p<.05$), and among participants with a

college degree or more education (83% to 90%, $p<.05$) (data not shown).



Most participants (88%) reported no one had smoked in their home in the seven days before the survey. This did not vary significantly by sex, age group, race, or the presence of children in the home.

More participants with a college degree or more education (94%) reported no one smoked in their home than participants with less education ($p < .05$; data not shown).

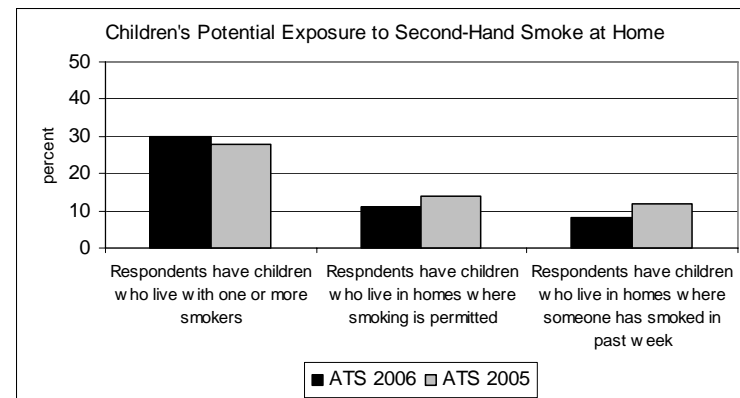
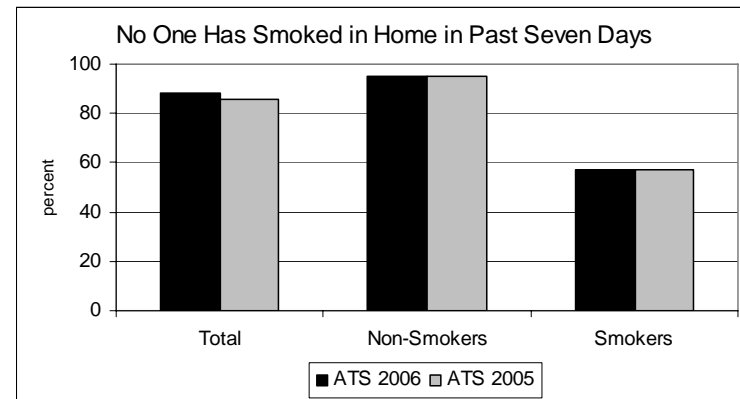
More non-smokers (95%) than smokers (57%) reported no one had smoked in their homes in the week before the survey ($p < .01$).

The proportion of participants who said no one smoked in their homes in the in the week before the survey increased between 2005 and 2006 among women (from 86% to 90%, $p < .05$), among participants age 35 to 54 (from 84% to 89%, $p < .05$), among participants with a college degree or more education (from 87% to 94%, $p < .05$), and among participants with children at home (from 88% to 92%, $p < .05$) (data not shown).

Children's Potential Exposure to Second-Hand Smoke at Home

In 2006, 40% of participants reported they had children age 17 or younger in their households. Thirty percent of those children lived in households where one or more adults smoked cigarettes, pipes, or cigars. However, only 11% of households with children permitted smoking

at any time or in any place in the home, and only 8% of participants with children reported that smoking had occurred in their home in the week before the survey. Although the proportion of children who lived with smokers increased slightly between 2005 and 2006, fewer children lived in homes that permitted smoking or where smoking had occurred in the week before the survey. None of the differences were statistically significant.



Section VI Work Environment

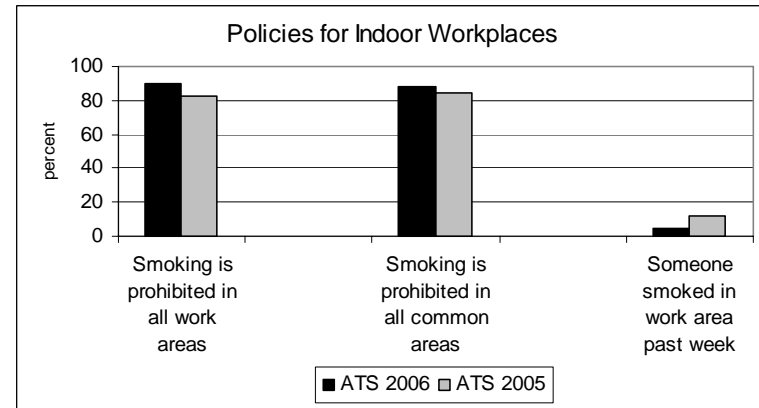
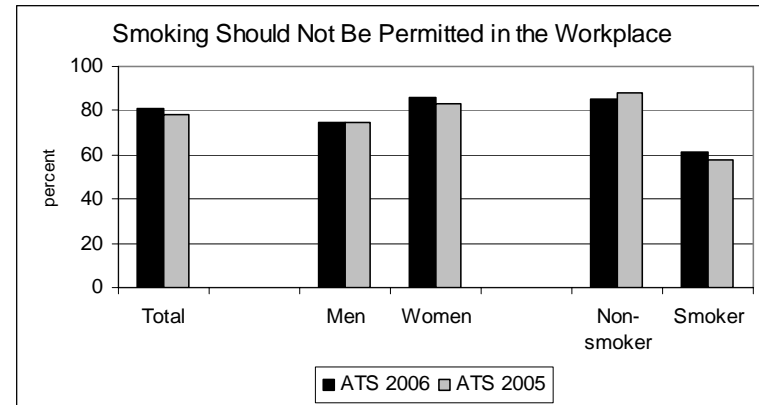
All participants were asked if they thought smoking should be allowed in all areas, some areas, or not at all in indoor work areas.

Overall, 81% believed smoking should be prohibited in all areas of the workplace. This is a significant increase over 2005 (78%, $p < .05$). More women (86%) than men (75%) believed smoking should be prohibited in all areas if the workplace ($p < .05$).

Fewer smokers (61%) than non-smokers (85%) were in favor of completely smoke-free workplaces ($p < .01$).

Support for smoke-free workplaces did not vary by age group, educational attainment, income, or race.

In 2006, 90% of indoor workers reported smoking was not permitted at all in work areas and 88% reported smoking was not permitted at all in common areas, compared to 83% and 84%, respectively, in 2005 (both $p < .05$). In 2006, 5% of indoor workers reported someone had smoked in their work area in the week before the survey, compared to 12% in 2005 ($p < .05$).



Section VII Public Policy

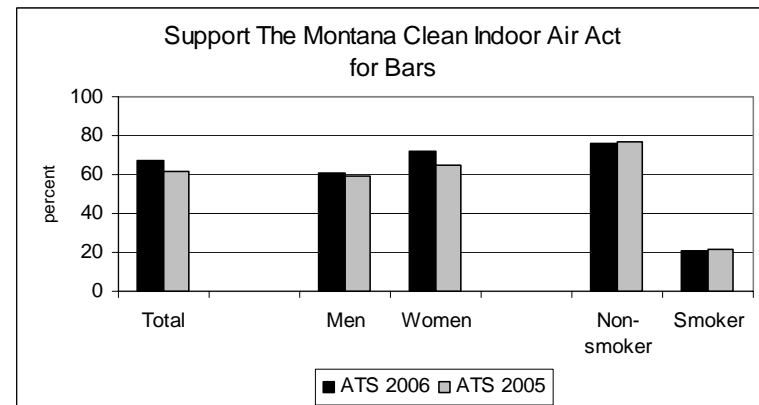
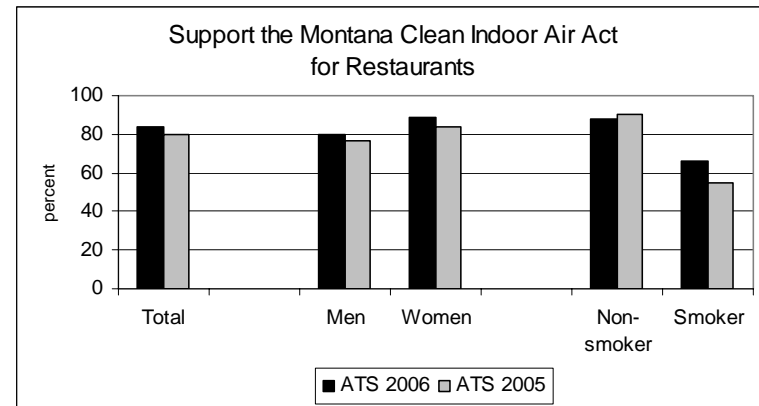
The Montana Clean Indoor Air Act

In 2006, 84% of participants approved of the Montana Clean Indoor Air Act (CIAA) as it currently applies to restaurants and 67% approved of it as it will apply to bars, taverns, and casinos in 2009. More women than men approved for both restaurants and bars ($p < .05$). Approval of the CIAA for both restaurants and bars was higher among non-smokers than smokers ($p < .01$). Support for the CIAA for restaurants and bars did not differ by age group, educational attainment, income, or race.

Although support for the CIAA as it applies to restaurants did not change significantly overall from 2005 to 2006, support increased among women (from 84% to 89%, $p < .05$), among participants age 35 to 54 (80% to 87%, $p < .05$, data not shown), and among participants with incomes above the state median (80% to 86%, $p < .05$, data not shown). Surprisingly, support also increased among smokers, from 55% in 2005 to 66% in 2006 ($p < .05$).

Support for the CIAA as it will apply to bars, taverns, and casinos in 2009 increased overall (from 62% to 67%, $p < .05$), among women (65% to 72%, $p < .05$), among participants age 35 to 54 (59% to 69%, $p < .05$, data not shown), among participants with a college degree or more education (66% to 71%, $p < .05$, data not shown),

and among those with incomes below the state median (58% to 65%, $p < .05$, data not shown).



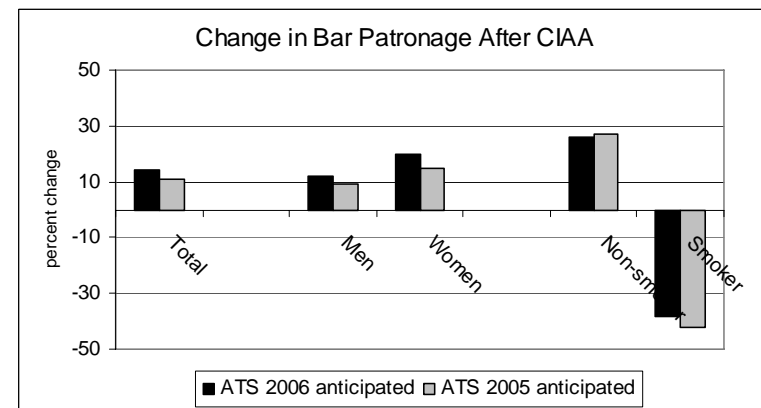
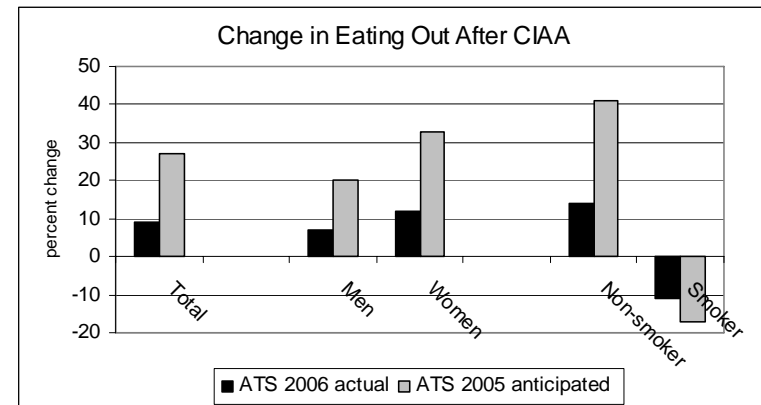
In both 2005 and 2006, more than half of the participants said the Clean Indoor Air Act would not change how often they ate out in restaurants or visited bars. The *net change* in eating out or bar patronage was calculated as the percent of participants who said they would visit each type of establishment more often, minus the percent of participants who said they would visit less often, after the CIAA went into effect.

In 2005, the net anticipated change in eating out was a 27% increase. In 2006, the net reported change was a 9% increase. Non-smokers anticipated a net increase of 41% in 2005, but reported a net increase of 14% in 2006. Smokers anticipated a net decrease of -17% in 2005, but reported a net decrease of -11% in 2006. This indicates that smokers reduced their restaurant patronage slightly after the CIAA went into effect, but the reduction was not as large as anticipated in 2005.

The anticipated net changes in bar patronage were similar in 2005 and 2006. In 2005, the net anticipated change in bar patronage was an 11% increase. In 2006, it was 14%. Non-smokers anticipated a net increase in bar patronage of 27% in 2005 and 26% in 2006. Smokers anticipated a net decrease in bar patronage of -42% in 2005 and of -35% in 2006. This indicates that smokers are expressing less likelihood of reducing their bar patronage after the CIAA goes into effect for bars.

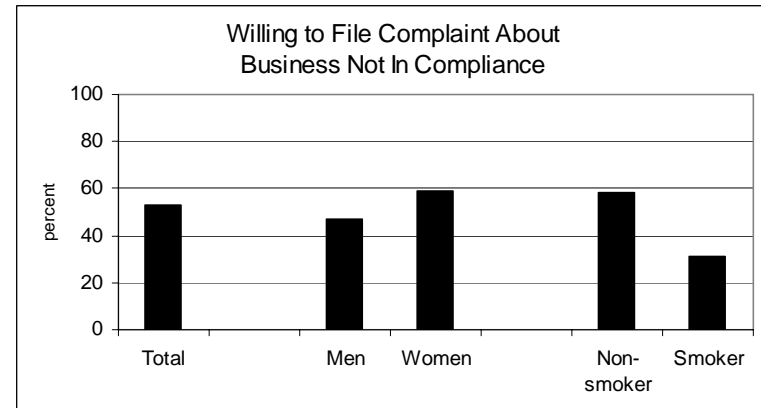
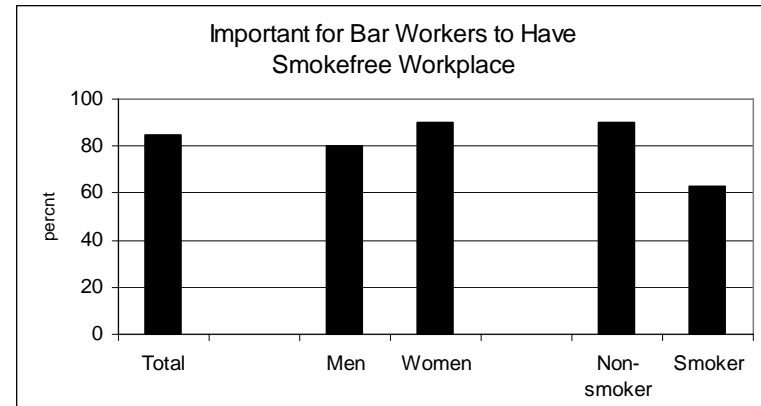
The net increase in eating out reported in 2006 by smokers after the CIAA went into effect was smaller than anticipated but was still positive at a 9% increase. The net decrease reported by smokers in 2006 was less than

anticipated in 2005. The anticipated net decrease in bar patronage by smokers was high but should be evaluated in light of the fact that only 17% of Montana adults are smokers. The anticipated total change in bar patronage, across all participants, is still an increase of 14%.



Most participants (85%) believed bar employees deserve to have a smoke-free workplace. More women (90%) than men (80%) endorsed this idea ($p < .05$). More non-smokers (90%) than smokers (63%) endorsed this idea ($p < .01$).

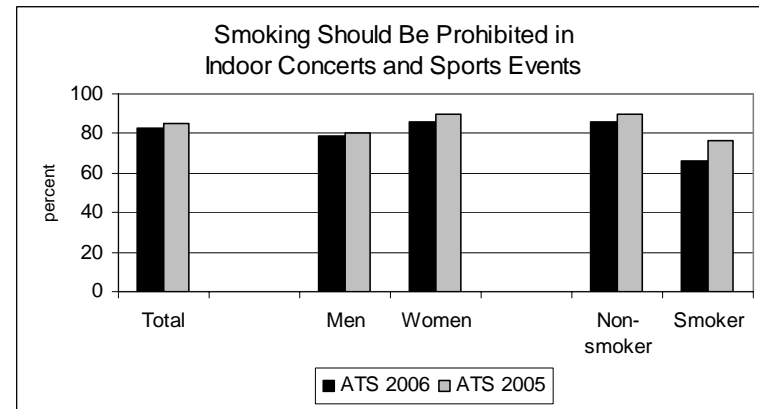
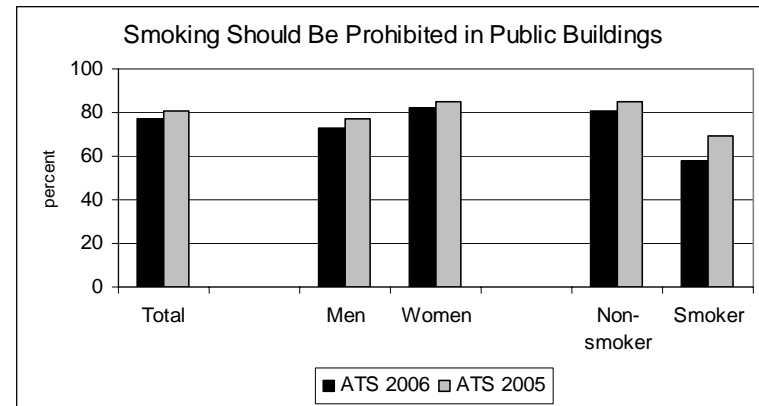
Only about half of the participants (53%) said they would be willing to file a complaint about a business not in compliance with the Montana Clean Indoor Air Act. More women (59%) than men (47%) said they would be willing to file a complaint ($p < .05$). More non-smokers (58%) than smokers (31%) said they would be willing to file a complaint ($p < .05$).



More than three quarters (77%) of participants believed public buildings should be smoke-free. More women (82%) than men (73%) were in favor of this ($p<.05$). There were no differences in support for the CIAA for public buildings by age, education, income, or race.

Fewer smokers (58%) than non-smokers (81%) supported smoke-free public buildings ($p<.01$).

Even more participants (83%) supported smoke-free indoor concerts and sporting events. More women (86%) than men (79%) supported this. There were no differences by age group, education, income, or race. Fewer smokers (66%) than non-smokers (86%) supported smoke-free concert and sports venues.

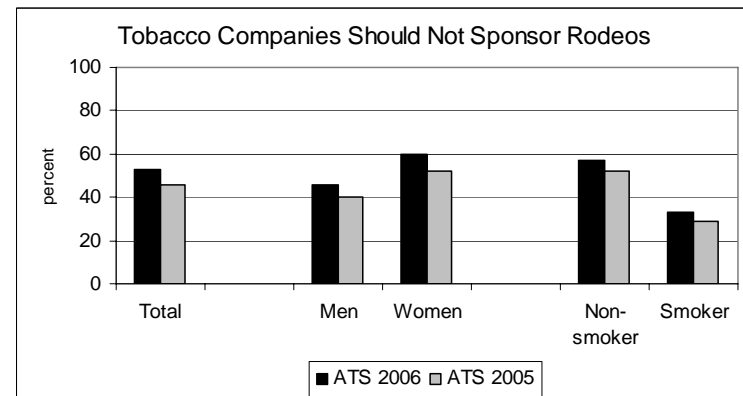
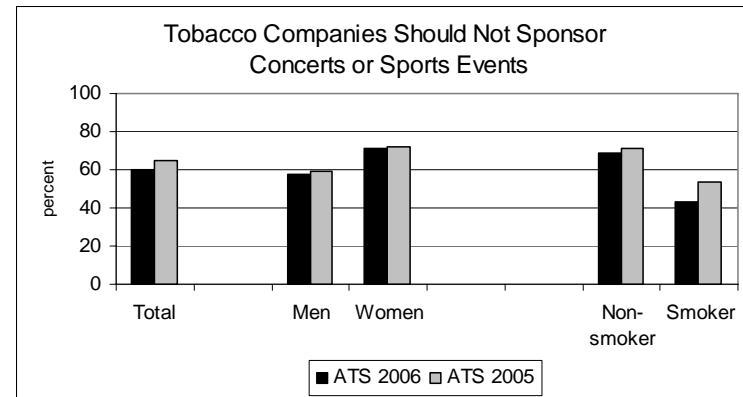


Tobacco Company Sponsorship

In 2006, 60% of participants said tobacco companies should not be allowed to sponsor concerts or sporting events, a decrease from 65% in 2005 ($p < .05$). In 2006, 53% said they should not be allowed to sponsor rodeos, up from 46% in 2005 ($p < .05$). More non-smokers than smokers disapproved of tobacco company sponsorship of these events ($p < .01$).

More women than men, and more American Indian than white participants, disapproved of tobacco company sponsorship ($p < .05$). There were no differences by age group, education, or income.

Disapproval of rodeo sponsorship increased from 2005 to 2006 overall, among both sexes, among participants with a college education or more, among participants with incomes both below and above the state median, and among non-smokers ($p < .05$).

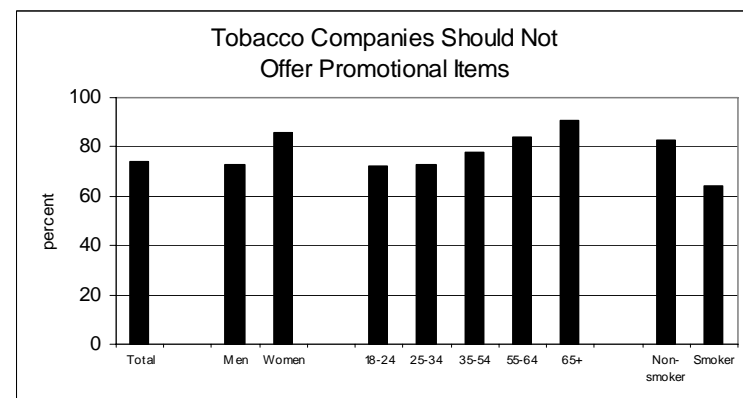
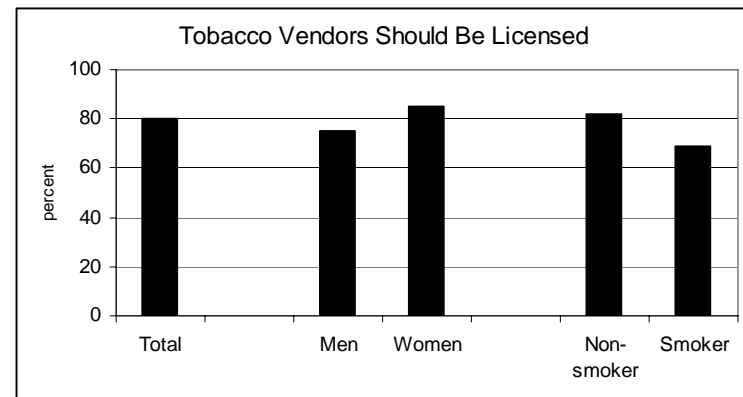
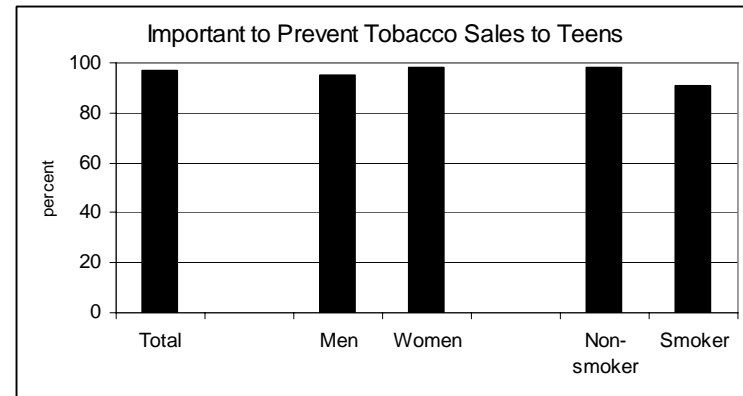


Tobacco Access by Teens

Overall, 97%% of participants said it was important to prevent the sales of tobacco products to teens. There were no significant differences in this position by sex, age group, educational attainment, income, or race. Although the difference between non-smokers (98%) and smokers (91%) was statistically significant ($p<.05$), smokers still overwhelmingly expressed support for preventing sales to teens.

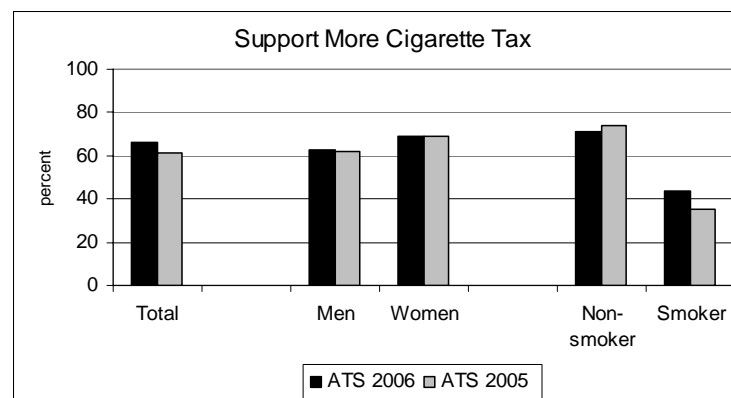
Overall, 80% of participants believed tobacco vendors should be licensed, similar to licensing requirements for alcohol vendors. More women (85%) than men (75%) supported licensing ($p<.05$). More American Indian (94%) than white participants (79%) supported licensing ($p<.05$). More non-smokers (82%) than smokers (69%) supported licensing ($p<.05$).

Seventy-four percent of participants said tobacco companies should not be allowed to offer promotional items such as jackets, t-shirt, or caps that might be appealing to teens. More women (86%) than men (73%) disapproved of promotional items. Fewer participants age 18 to 24 and 25 to 34 than older participants disapproved of promotional items ($p<.05$). More non-smokers (83%) than smokers (64%) disapproved of promotional items ($p<.01$).



Cigarette Tax

Overall, 66% of participants would support additional taxes on cigarettes. This is an increase from 61% in 2005 ($p < .05$). Support for more cigarette tax did not vary by sex, age group, educational attainment, income, or race. More non-smokers (71%) than smokers (44%) supported additional tax ($p < .05$). However, among smokers, this is an increase from 2005 (35%, $p < .05$).



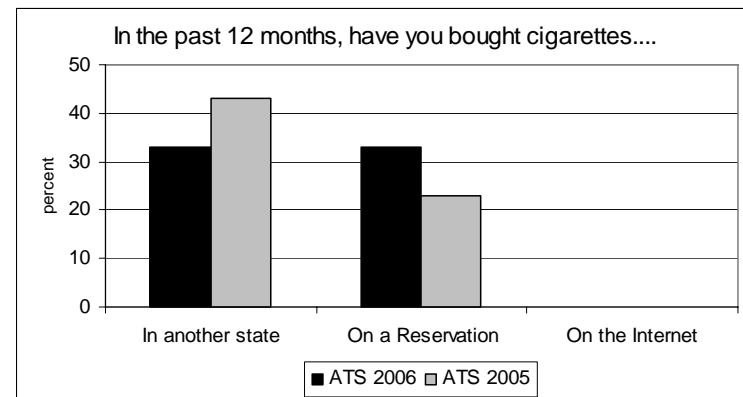
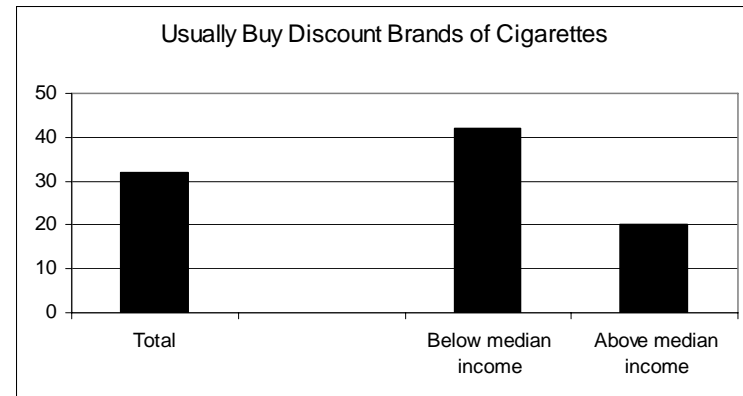
Section VIII Tobacco Purchasing Patterns

Overall, 32% of smokers said they usually bought discount brands of cigarettes. There were too few participants to conduct analysis by age group or educational attainment. More than twice as many participants with incomes below the state median (42%) than participants with incomes above the median (20%) said they usually bought discount brands ($p < .05$).

In 2006, 33% of participants said they bought cigarettes in another state, down from 43% in 2005 ($p < .05$). There were too few participants to conduct analysis by age group. There were no differences by sex, educational attainment, income, or race.

In 2006, 33% of participants said they bought cigarettes on an Indian Reservation, up from 23% in 2005 ($p < .05$). There were too few participants to conduct analysis by age group. There were no differences by educational attainment or income. More American Indian participants (80%) than white participants (25%) ($p < .05$) bought their cigarettes on Reservations, but this does not account for the overall increase in purchasing in Reservations, which is adjusted for race of the participants.

Very few participants said they purchased cigarettes over the internet.



Summary and Recommendations

Summary and Recommendations

1. Tobacco cessation messages and outreach should be targeted.

Smoking was more common among

- Participants age 18 to 34
- Participants with less than a college education
- American Indians

Spit tobacco was used almost exclusively by men, and most often among men with a high school education or less.

2. Two thirds of smokers and half of spit tobacco users want to quit but most underutilize aids to quitting.

Nearly all participants who smoke or use spit tobacco were aware of assistance to quitting but few used any in their last quit attempt and few anticipated using them in a future quit attempt.

3. There is a role for health care workers in tobacco cessation.

- Two thirds or more of smokers and spit tobacco users had seen a health care professional and a dentist in the year before the survey.
- Of the smokers who saw a health care professional or dentist, only two thirds were advised not to smoke.
- Fewer than one third of smokers were offered or referred to assistance to quit by a health care professional.

4. Awareness of the health risks of smoking is not as high as it should be in Montana.

- Nearly a quarter of participants did not believe that smoking causes heart attacks or stroke.
- Nearly two thirds did not believe that smoking causes impotence.
- Awareness of the risks of smoking in pregnancy was high.

5. Awareness of the health risks of second-hand smoke is modest.

- 91% knew that second-hand smoke was harmful to adults' health.
- 86% identified lung cancer and heart disease as major health risks of second-hand smoke.
- 91% knew that second-hand smoke caused respiratory problems in children.
- Only 38% knew that second-hand smoke contributed to the risk of Sudden Infant Death Syndrome.

6. Many Montana residents are taking steps to protect themselves and their families from second-hand smoke at home.

- 84% did not permit smoking at all in their homes.
- Only 11% of participants with children permitted smoking in their homes.

7. Most Montana residents want to be protected from second-hand smoke in public places.

- 81% believed workplaces should be completely smoke-free.
- 84% approved of the Montana Clean Indoor Air Act as it applies to restaurants.
- Support for the Montana Clean Indoor Air Act as it will apply to bars, taverns, and casinos has increased since 2005.
- 85% of Montanans believed bar workers should have a smoke-free workplace.

8. Public policy can affect personal behavior.

- 97% of Montanans believed it is important to prevent the sales of tobacco products to teens.
- 80% believed tobacco vendors should be licensed.
- 66% would support additional cigarette tax.
- 32% of smokers bought discount brands of cigarettes, suggesting that pricing influences smoking choices.

Appendix 1

Data Tables

All percentages in Tables II through VIII are adjusted by multiple logistic regression to reflect the simultaneous effects of sex, age, education, income, race, and smoking status.

Section I
Characteristics of the Sample

	% ATS 2006	% ATS 2005	Census 2000
Sex			
Male	49	49	50
Female	51	51	50
Age Group			
18-24	14	14	12
25-34	15	15	13
35-54	38	38	36
55-64	15	15	23
65+	18	18	16
Education			
High school or less	36		44
More than high school	27	66	34
College graduate or more	37	34	22
Income			
Below state median	46	41	50
Above state median	54	59	50
Marital Status			
Married/Couple	67	68	57
Single	33	32	43
Children in Home			
Yes	40	36	33
No	60	64	67
Employment Status			
Employed	64	61	65
Retired	19	19	
Student	3	7	
Homemaker	6	8	
Unemployed	8	5	5
Insurance Coverage			
Yes #	82	81	85
No	18	19	15
Race			
White	91	93	91
American Indian	6	5	7
All other	3	2	2

Excludes Medicaid and Medicare

Section II
Prevalence of Tobacco Use

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Current smoker				
Total	17		18	
Men	17	p < .05	21	
Women	16		16	
18-24	27	p < .05	*	
25-34	23		19	
35-54	17		22	p < .05
55-64	12		12	
65+	6		*	
High school or less	24			
More than high school	15		21	
College graduate or more	10		11	
Below median income	14		25	p < .05
Above median income	19		13	p < .05
White	16		*	
American Indian	26		*	
Current smokeless tobacco user				
Total	6		7	
Men	12		13	
Women	*		*	
	Men only		Men only	
18-24	*		*	
25-34	*		*	
35-54	*		*	
55-64	*		*	
65+	*		*	
High school or less	17		*	
More than high school	9		*	
College graduate or more	7		*	
Below median income	10		*	
Above median income	13		*	
White	12		*	
American Indian	*		*	

* indicates fewer than 20 respondents

	% ATS 2006	
	Cigar	Pipe
Total	3	1
Men	9	1
Women	*	*
	Men only	Men only
18-24	*	*
25-34	*	*
35-54	*	*
55-64	*	*
65+	*	*
High school or less	*	*
More than high school	*	*
College graduate or more	*	*
Below median income	*	*
Above median income	*	*
White	*	*
American Indian	*	*
Cigarette non-smoker	3	*
Cigarette smoker	13	*

p < .05

* indicates fewer than 20 respondents

Section III Tobacco Cessation

		Cigarettes		Year comparison	Smokeless tobacco		Year comparison
		ATS 2006	ATS 2005		ATS 2006	ATS 2005	
					Men Only		
Want to quit		66	n/a		47	n/a	
Tried to quit past year		49	50		n/a	34	
In your last quit attempt, did you use							
	NRT	25	34	p < .05			
	Medication	9	n/a				
	Classes	*	n/a				
	Counseling	*	n/a				
	QuitLine	*	5				
	Self-help	9	n/a				
Consider quitting in next 6 months		62	61		48	47	
Plan to quit in next 30 days		45	45		62	52	
Are you							
	Aware of assistance	81	80				
	Likely to use						
	NRT	45	n/a				
	Medication	20	n/a				
	Class or counseling	26	15	p < .05			
	QuitLine	39	21	p < .05			
	Self-help	33	33				

n/a indicates question not asked

* indicates fewer than 20 respondents

Health Care Professional Assistance

	% ATS 2006	% ATS 2005	Year comparison
Seen health care professional in past 12 months			
Total	75	74	
Smokers	70	61	p < .05
Smokeless tobacco users	68	61	
Did health care professional			
Ask you if you smoke	65	63	
Advise you not to smoke	60	68	
Recommend NRT	28	32	
Prescribe medication	13	n/a	
Suggest class, counseling	20	17	
Suggest QuitLine	26	16	
Suggest setting date	28	23	
Offer self-help	26	29	
Did you see dentist in past 12 months?			
Total	69	n/a	
Smokers	62	n/a	
Smokeless tobacco users	74	n/a	
Did dentist			
Advise you not to smoke	44	n/a	
Recommend NRT	23	n/a	
Suggest class, counseling	*	n/a	
Suggest QuitLine	*	n/a	
Offer self-help	*	n/a	

n/a indicates question not asked

* indicates fewer than 20 respondents

Section IV
Knowledge of Health Risks of Tobacco

	% ATS 2006			% ATS 2006	
	Smoking causes heart attack	Category comparison		Smoking causes stroke	Category comparison
Total	77			75	
Men	73			71	
Women	80			79	
18-24	76			74	
25-34	75			75	
35-54	82			80	
55-64	74			70	
65+	71			71	
High school or less	74			72	
More than high school	77			76	
College graduate or more	80			77	
Below median income	73			73	
Above median income	80			77	
White	76			74	
American Indian	76			78	
Non-smoker	80	p < .05		78	p < .05
Smoker	63			62	

	%			%	
	ATS			ATS	
	2006			2006	
	Smoking causes lung cancer	Category comparison		Smoking causes impotence	Category comparison
Total	95			40	
Men	94			39	
Women	96			40	
18-24	96			43	
25-34	97			46	
35-54	97			41	
55-64	92			34	
65+	90			34	
High school or less	95			36	
More than high school	96			37	
College graduate or more	95			45	
Below median income	94			41	
Above median income	96			38	
White	95			39	
American Indian	97			40	
Non-smoker	96	p < .05		43	p < .05
Smoker	87			25	

		% ATS 2006			
Smoking while pregnant can harm the baby		Category comparison		Smoking causes low birth weight	Category comparison
Total	95			82	
Men	94			75	p < .01
Women	96			89	
18-24	98			92	p < .05
25-34	97			90	
35-54	97			86	
55-64	91			77	
65+	89			65	
High school or less	93			80	
More than high school	95			82	
College graduate or more	97			86	
Below median income	94			81	
Above median income	96			84	
White	95			82	
American Indian	97			85	
Non-smoker	96	p < .05		84	p < .05
Smoker	89			72	

	% ATS 2006			
	Smoking is addictive	Category comparison	It is beneficial to quit smoking	Category comparison
Total	96		78	
Men	96		79	
Women	96		83	
18-24	97		80	
25-34	99		83	
35-54	98		84	
55-64	97		82	
65+	95		74	
High school or less	97		74	p < .05
More than high school	97		85	
College graduate or more	95		87	
Below median income	97		79	
Above median income	96		84	
White	96		82	
American Indian	98		69	
Non-smoker	97		83	
Smoker	92		75	

Second-Hand Smoke					
	% ATS 2006	Category comparison	% ATS 2005	Year comparison	
Second-hand smoke is harmful to one's health					
Total	91		93		
Men	87	p < .05	91	p < .05	
Women	95		96		
18-24	94		96		
25-34	97		95		
35-54	93		93		
55-64	87		90		
65+	83		90		
High school or less	90				
More than high school	93		92		
College graduate or more	91		95		
Below median income	91		93		
Above median income	92		93		
White	91		*		
American Indian	96		*		
Non-smoker	94	p < .05	97		
Smoker	77		83		
Second-hand smoke causes heart disease					
Total	76		75		
Men	75		70	p < .05	
Women	78		80		
18-24	78		71		
25-34	82		77		
35-54	79		76		
55-64	70		72		
65+	70		74		
High school or less	72				
More than high school	77		73		
College graduate or more	80		79		
Below median income	75		76		
Above median income	78		74		
White	75		*		
American Indian	84		*		
Non-smoker	78	p < .05	77		
Smoker	65		66		

	% ATS 2006	Category comparison	% ATS 2005	Year Comparison
Second-hand smoke causes lung cancer				
Total	86		86	
Men	84		82	
Women	88		89	
18-24	89		87	
25-34	91		88	
35-54	88		87	
55-64	80		80	
65+	79		82	
High school or less	84			
More than high school	85		85	
College graduate or more	88		88	
Below median income	84		85	
Above median income	87		86	
White	85		*	
American Indian	92		*	
Non-smoker	88	p < .05	90	
Smoker	76		71	
Second-hand smoke causes respiratory problems in children				
Total	91		91	
Men	89		89	
Women	93		94	
18-24	89		95	
25-34	96		94	
35-54	93		91	
55-64	88		88	
65+	86		91	
High school or less	89			
More than high school	93		90	
College graduate or more	91		93	
Below median income	91		93	
Above median income	90		90	
White	90		*	
American Indian	96		*	
Children in home	94		n/a	
No children in home	89		n/a	
Non-smoker	93	p < .05	94	
Smoker	79		85	

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Second-hand smoke causes Sudden Infant Death Syndrome				
Total	38		36	
Men	34		29	p < .05
Women	42		45	
18-24	59	p < .05	48	
25-34	48		47	
35-54	37		38	
55-64	26		23	
65+	27		26	
High school or less	34			
More than high school	41		37	
College graduate or more	40		36	
Below median income	39		46	p < .05
Above median income	37		31	p < .05
White	37		*	
American Indian	50		*	
Children in home	40		n/a	
No children in home	36		n/a	
Non-smoker	40		42	
Smoker	29		28	

n/a indicates question not asked

* indicates fewer than 20 respondents

Section V
Home Environment

Live with smokers

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	21		23	
Men	21		22	
Women	22		24	
18-24	31		31	
25-34	17		19	
35-54	19		24	p < .05
55-64	21		21	
65+	21		19	
High school or less	24			
More than high school	22		23	
College graduate or more	18		24	p < .05
Below median income	22		27	p < .05
Above median income	21		21	
White	20		*	
American Indian	32		*	
Children in home	21		28	p < .05
No children in home	22		34	p < .05
Non-smoker	13	p < .01	12	
Smoker	61		61	

* indicates fewer than 20 respondents

Smoking not permitted in home

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	84		81	
Men	81	p < .05	79	
Women	88		84	p < .05
18-24	87		86	
25-34	86		88	
35-54	85		80	p < .05
55-64	80		81	
65+	81		75	p < .05
High school or less	79	p < .05		
More than high school	84		81	
College graduate or more	90		83	p < .05
Below median income	84		78	p < .05
Above median income	84		85	
White	85		*	
American Indian	73		*	
Children in home	89		86	
No children in home	81		79	
Non-smoker	91		92	
Smoker	53	p < .01	50	

* indicates fewer than 20 respondents

No one smoked in home

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	88		86	
Men	86		85	
Women	90		86	p < .05
18-24	89		87	
25-34	89		86	
35-54	89		84	p < .05
55-64	85		85	
65+	87		87	
High school or less	85	p < .05		
More than high school	86		84	
College graduate or more	94		87	p < .05
Below median income	88		85	
Above median income	88		87	
White	89		*	
American Indian	80		*	
Children in home	92		88	p < .05
No children in home	86		85	
Non-smoker	95	p < .01	95	
Smoker	57		50	
Children live with one or more smokers	30		28	
Children live in households where smoking is permitted in some places or at some times.	11		14	
Children live in homes where someone smoked inside on one or more days in past week	8		12	

* indicates fewer than 20 respondents

Section VI
Work Environment

Smoking should not be permitted in any part of the workplace (all respondents)

	% ATS 2006	Category comparison	% AST 2005	Year comparison
Total	81		78	p < .05
Men	75	p < .05	75	
Women	86		83	
18-24	82		76	
25-34	83		81	
35-54	85		79	
55-64	76		83	
65+	73		76	
High school or less	78			
More than high school	81		77	
College graduate or more	85		84	
Below median income	78		76	
Above median income	83		81	
White	81		*	
American Indian	77		*	
Non-smoker	85	p < .01	88	
Smoker	61		58	

Workplace Smoking Policy for Indoor Workers

	% ATS 2006		% ATS 2005	
Smoking is prohibited in all work areas	90		83	p < .05
Smoking is prohibited in all common areas	88		84	p < .05
Someone smoked in work area past week	5		12	p < .05

* indicates fewer than 20 respondents

**Section VII
Public Policy**

	ATS 2006	Category comparison	AST 2005	Year comparison
Support the Montana Clean Indoor Air Act for restaurants				
Total	84		80	
Men	80	p < .05	77	
Women	89		84	p < .05
18-24	80		78	
25-34	89		85	
35-54	87		80	p < .05
55-64	82		83	
65+	80		76	
High school or less	81			
More than high school	88		78	
College graduate or more	85		86	
Below median income	83		80	
Above median income	86		80	p < .05
White	84		*	
American Indian	81		*	
Non-smoker	88	p < .01	90	
Smoker	66		55	p < .05
Support the Montana Clean Indoor Air Act for bars				
Total	67		62	p < .05
Men	61	p < .05	59	
Women	72		65	p < .05
18-24	61		69	
25-34	65		59	
35-54	69		59	p < .05
55-64	66		68	
65+	68		66	
High school or less	63			
More than high school	66		59	
College graduate or more	71		66	p < .05
Below median income	65		58	p < .05
Above median income	68		64	
White	66		*	
American Indian	67		*	
Non-smoker	76	p < .001	77	
Smoker	21		22	

Net change in eating out after Clean Indoor Air Act

	% ATS 2006 Actual	Category comparison	% ATS 2005 Anticipated	Year comparison
Total	9		27	
Men	7		20	
Women	12		33	
18-24	3		*	
25-34	15		*	
35-54	12		*	
55-64	12		*	
65+	3		*	
High school or less	4			
More than high school	10		23	
College graduate or more	12		32	
Below median income	9		24	
Above median income	10		28	
White	9		*	
American Indian	4		*	
Non-smoker	14		41	
Smoker	-11		-17	

Net change predicted in bar patronage after Clean Indoor Air Act

Total	14		11	
Men	12		9	
Women	20		15	
18-24	19		10	
25-34	24		6	
35-54	16		6	
55-64	13		-7	
65+	19		-17	
High school or less	9			
More than high school	12		9	
College graduate or more	23		17	
Below median income	11		7	
Above median income	19		15	
White	16		*	
American Indian	15		*	
Non-smoker	26		27	
Smoker	-35		-42	

It is important for bar workers to have smoke free work place

	% ATS 2006	Category comparison
Total	85	
Men	80	p < .05
Women	90	
18-24	78	
25-34	87	
35-54	87	
55-64	85	
65+	86	
High school or less	83	
More than high school	87	
College graduate or more	86	
Below median income	85	
Above median income	85	
White	85	
American Indian	89	
Non-smoker	90	p < .01
Smoker	63	

Willing to file complaint about business not in compliance with Clean Indoor Air Act

Total	53	
Men	47	p < .05
Women	59	
18-24	52	
25-34	52	
35-54	55	
55-64	56	
65+	49	
High school or less	48	
More than high school	51	
College graduate or more	60	
Below median income	53	
Above median income	53	
White	52	
American Indian	65	
Non-smoker	58	p < .05
Smoker	31	

Smoking should be prohibited in public buildings

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	77		81	p < .05
Men	73	p < .05	77	
Women	82		85	
18-24	76		84	p < .05
25-34	80		83	
35-54	81		81	
55-64	74		83	p < .05
65+	72		79	p < .05
High school or less	74			
More than high school	75		80	
College graduate or more	82		86	
Below median income	75		83	p < .05
Above median income	80		80	
White	77		*	
American Indian	79		*	
Non-smoker	81	p < .01	85	p < .05
Smoker	58		69	p < .05

Smoking should not be allowed in indoor concerts and sports events

Total	83		85	
Men	79	p < .05	80	
Women	86		90	p < .05
18-24	77		70	p < .05
25-34	77		82	
35-54	83		85	
55-64	86		91	
65+	88		93	
High school or less	80			
More than high school	82		82	
College graduate or more	86		90	
Below median income	80		84	
Above median income	85		85	p < .05
White	83		*	
American Indian	80		*	
Non-smoker	86	p < .01	90	
Smoker	66		76	p < .05

Tobacco companies should not be allowed to sponsor concerts or sports events

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	60		65	p < .05
Men	58	p < .05	59	
Women	71		72	
18-24	49		52	
25-34	63		64	
35-54	64		63	
55-64	68		72	
65+	75		78	
High school or less	64			
More than high school	68		66	
College graduate or more	61		64	
Below median income	67		66	
Above median income	62		65	
White	62	p < .05	*	
American Indian	82		*	
Non-smoker	69	p < .01	71	
Smoker	43		54	p < .05

Tobacco companies should not be allowed to sponsor rodeos

Total	53		46	p < .05
Men	46	p < .05	40	p < .05
Women	60		52	p < .05
18-24	38		31	
25-34	53		45	
35-54	53		43	p < .05
55-64	60		57	
65+	59		56	
High school or less	52			
More than high school	57		46	
College graduate or more	51		46	p < .05
Below median income	56		48	p < .05
Above median income	51		44	p < .05
White	51		*	
American Indian	71		*	
Non-smoker	57	p < .01	52	p < .05
Smoker	33		29	

	% ATS 2006	Category comparison
It is important to prevent the sales of tobacco products to teens		
Total	97	
Men	95	
Women	98	
18-24	95	
25-34	97	
35-54	98	
55-64	98	
65+	96	
High school or less	96	
More than high school	99	
College graduate or more	97	
Below median income	97	
Above median income	97	
White	97	
American Indian	99	
Non-smoker	98	p < .05
Smoker	91	
Tobacco vendors should be licensed		
Total	80	
Men	75	p < .05
Women	85	
18-24	85	
25-34	88	
35-54	78	
55-64	73	
65+	81	
High school or less	77	
More than high school	82	
College graduate or more	82	
Below median income	81	
Above median income	79	
White	79	p < .05
American Indian	94	
Non-smoker	82	p < .05
Smoker	69	

Tobacco companies should not be allowed to offer promotional items

Total	74	
Men	73	p < .05
Women	86	
18-24	72	p < .05
25-34	73	
35-54	78	
55-64	84	
65+	91	
High school or less	81	
More than high school	80	
College graduate or more	77	
Below median income	77	
Above median income	81	
White	78	
American Indian	86	
Non-smoker	83	p < .05
Smoker	64	

Support more cigarette tax	ATS 2006	Category comparison	ATS 2005	Year comparison
Total	66		61	p < .05
Men	63		62	
Women	69		69	
18-24	68		65	
25-34	71		72	
35-54	68		64	
55-64	59		64	
65+	62		63	
High school or less	62			
More than high school	66		61	
College graduate or more	71		73	
Below median income	63		67	
Above median income	69		64	
White	67		*	
American Indian	68		*	
Non-smoker	71	p < .05	74	
Smoker	44		35	p < .05

**Section VIII
Purchasing Patterns**

	% ATS 2006	Category comparison
Usually buy discount brands		
Total	32	
Men	36	
Women	29	
18-24	*	
25-34	*	
35-54	*	
55-64	*	
65+	*	
High school or less	*	
More than high school	*	
College graduate or more	*	
Below median income	42	p < .05
Above median income	20	
White	34	
American Indian	20	

Bought cigarettes in other state in past year

	ATS 2006	Category comparison	% ATS 2005	Year comparison
Total	33		43	p < .05
Men	32			*
Women	32			*
18-24	*			*
25-34	*			*
35-54	*			*
55-64	*			*
65+	*			*
High school or less	22			*
More than high school	42			*
College graduate or more	49			*
Below median income	30			*
Above median income	35			*
White	33			*
American Indian	29			*

* indicates fewer than 20 respondents

	% ATS 2006	Category comparison	% ATS 2005	Year comparison
Bought cigarettes on Indian Reservation in past year				
Total	33		23	p < .05
Men	36		*	
Women	31		*	
18-24	*		*	
25-34	*		*	
35-54	*		*	
55-64	*		*	
65+	*		*	
High school or less	25		*	
More than high school	36		*	
College graduate or more	55		*	
Below median income	35		*	
Above median income	32		*	
White	25	p < .05	*	
American Indian	80		*	

Bought cigarettes on the internet in past year

Total	*	*
Men	*	*
Women	*	*
18-24	*	*
25-34	*	*
35-54	*	*
55-64	*	*
65+	*	*
High school or less	*	*
More than high school	*	*
College graduate or more	*	*
Below median income	*	*
Above median income	*	*
White	*	*
American Indian	*	*

* indicates fewer than 20 respondents

Appendix 2

Montana Adult Tobacco Survey 2006 Questionnaire

Montana Adult Tobacco Survey 2006

1. Would you say that in general your health is:
Excellent
Very good
Good
Fair
Poor
2. Have you smoked at least 100 cigarettes in your entire life?
3. Do you now smoke cigarettes everyday, some days, or not at all?
4. On the average, about how many cigarettes a day do you now smoke?
5. During the past 30 days, on how many days did you smoke cigarettes?
6. On the average, on days when you smoked during the past 30 days, about how many cigarettes did you smoke a day?
8. About how long has it been since you last smoked cigarettes regularly?
- MT01. Do you want to quit smoking?
9. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?
- MT02. When you quit smoking / The last time you tried to quit smoking, did you use the nicotine patch, nicotine gum, or any other form of nicotine replacement therapy to help you quit?
- MT03. Did you use a prescription medication such as Bupropion, Wellbutrin, or Zyban?
- MT04. Did you use a stop smoking class?
- MT05. Did you use a toll-free telephone QuitLine?
- MT06. Did you use one-on-one counseling from a doctor or nurse?
- MT07. Did you use self help materials such as books or videos?
12. Are you seriously considering stopping smoking within the next six months?
13. Are you planning to stop smoking within the next 30 days?

- MT08. Are you aware of assistance that might be available to help you quit smoking, such as telephone quit lines and local health clinics?
- MT09. [When you] / [the next time you] try to quit smoking, will you very likely, somewhat likely, not very likely, or not at all likely to use the following aids to quitting?
- a nicotine patch, nicotine gum, or any other form of nicotine replacement therapy?
 - a prescription medication such as Bupropion, Welbutrin, or Zyban?
 - a stop smoking class, program or counseling?
 - a toll-free telephone Quit Line?
 - self help materials such as books or videos?
14. In the past 12 months, have you seen a doctor, nurse, or other health professional to get any kind of care for yourself?
15. During the past 12 months, did any doctor, nurse, or other health professional advise you to not smoke?
16. During the past 12 months, did any doctor, nurse, or other health professional ask if you smoke?
17. In the past 12 months, when a doctor, nurse, or other health professional advised you to quit smoking, did they also do any of the following?
- Prescribe or recommend a patch, nicotine gum, nasal spray, an inhaler, or other form of nicotine replacement therapy?
 - Prescribe medications such as Bupropion, Welbutrin, or Zyban ?
 - Suggest that you set a specific date to stop smoking?
 - Suggest that you use a smoking cessation class, program, quit line, or counseling?
 - Provide you with booklets, videos, or other materials to help you quit smoking on your own?
 - Suggest that you call a toll-free telephone QuitLine?
18. Not including yourself, how many of the adults who live in your household smoke cigarettes, cigars or pipes?
19. During the past 7 days, on how many days did anyone smoke cigarettes, cigars, or pipes anywhere inside your home?
20. Which statement best describes the rules about smoking inside your home? Do not include decks, garages, or porches. Not permitted at all, permitted at some times or in some places, permitted any time or any place, no rules.

21. Are you currently...
- A student and employed for wages part-time or full-time
 - A student
 - Employed for wages part-time or full-time
 - Self-employed
 - Out of work for more than 1 year
 - Out of work for less than 1 year
 - A homemaker
 - Retired
 - Unable to work
22. While working at your job, are you indoors most of the time?
23. As far as you know, in the past seven days, has anyone smoked in your work area?
24. Which of the following best describes your place of work's official smoking policy for work areas?
- Not allowed in any work areas
 - Allowed in some work areas
 - Allowed in all work areas
 - No official policy
25. Which of the following best describes your place of work's official smoking policy for indoor public or common areas, such as lobbies, rest rooms, and lunchrooms?
- Not allowed in any public areas
 - Allowed in some public areas
 - Allowed in all public areas
 - No official policy
26. In indoor work areas, do you think smoking should be allowed in all areas, some areas or not at all?
27. In the past seven days, have you been in a car with someone who was smoking?
30. If a person has smoked a pack of cigarettes a day for more than 20 years, there is little health benefit to quitting smoking.
- Strongly agree
 - Agree
 - Disagree
 - Strongly disagree

31. Do you think that breathing smoke from other people's cigarettes is
Very harmful to one's health
Harmful to one's health
Not very harmful to one's health
Not harmful at all to one's health
32. Would you say that breathing smoke from other people's cigarettes causes:
Lung cancer in adults
Heart disease in adults
Colon cancer in adults
Respiratory problems in children
Sudden infant death syndrome
39. What is the highest level of school you completed or the highest degree you received?
40. What is your annual household income from all sources?
- A.3 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?
- MT13. Do you usually smoke a discount, or generic, brand?
- MT14. Do you usually smoke regular, light, or ultra light cigarettes?
- MT15. In the last 12 months have you ever bought cigarettes in a neighboring state?
- MT16. In the last 12 months have you ever bought cigarettes on an Indian reservation?
- MT17. In the last 12 months have you ever bought cigarettes on the Internet?
- MT18. Do you currently use chewing tobacco or snuff every day, some days, or not at all?
- MT19. Do you want to quit using chewing tobacco or snuff?
- MT20. Are you seriously considering stopping using chewing tobacco or snuff within the next 6 months?
- MT21. Are you seriously considering stopping using chewing tobacco or snuff with the next 30 days?
- MT22. Do you now smoke cigars every day, some days, or not at all?
- MT23. Do you now smoke a pipe every day, some days, or not at all?

- D.3 In public buildings, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?
- MT24. In the indoor dining area of restaurants, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?
- MT25. In bars, taverns, and casinos, do you think smoking should be allowed in all areas, some areas or not at all?
- D.6 In indoor sporting events and concerts, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?
- E.1 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe smoking cigarettes is a cause of this condition.
- Heart attack
 - Stroke
 - Lung cancer
 - Impotence
 - Low birth weight
- E2. I'm going to read you a series of statements. After I finish, please tell me whether you strongly agree, agree, disagree, or strongly disagree with the statement.
- Smoking is physically addictive.
 - Smoking light cigarettes is safer than smoking regular cigarettes.
 - Smoking by a pregnant woman may harm the baby.
- F.1 How important is it that communities keep stores from selling tobacco products to teenagers. Would you say it is:
- Very important
 - Somewhat important
 - Not very important
 - Not important at all
- F.3 How strongly do you agree or disagree with the following statement:
Storeowners should be required to have a license to sell tobacco products, similar to alcohol, so that teens can't buy tobacco products.
- Strongly Agree
 - Agree
 - Disagree
 - Strongly Disagree

MT27. Beginning last year, the Montana Clean Indoor Air Act prohibits smoking in all public buildings and restaurants. Do you

- Approve strongly
- Approve somewhat
- Disapprove somewhat
- Disapprove strongly

MT28. The Montana clean Indoor Air Act prohibits smoking in restaurants in Montana. As a result of this law, in the past year have you eaten out in restaurants more often, less often, or has the law not affected how often you go out to eat?

- More often
- Less often
- No effect (include doesn't eat out in restaurants)

MT29. In October 2009, the Montana Clean Indoor Air Act will also prohibit smoking in bars, taverns and casinos. Do you

- Approve strongly
- Approve somewhat
- Disapprove somewhat
- Disapprove strongly

MT30. When the law prohibiting smoking in bars, taverns, and casinos takes effect, will you be more likely to visit them, less likely to visit them, or will the law not affect how often you will visit bars, taverns, and casinos?

- More likely
- Less likely
- No change

MT31. How important do you think it is for employees of bars, taverns and casinos to have a smoke-free workplace?

- Very important
- Somewhat important
- Not very important
- Not important at all

MT32. Enforcement of the Montana Clean Indoor Air Act depends on complaints filed by citizens or official inspectors. If you visited a business that was not complying with the Clean Indoor Air Act, how likely would you be to file a complaint?

- Very likely
- Somewhat likely
- Not very likely
- Not at all likely

MT33. In the past 12 months have you visited school grounds or attended a school-sponsored event?

MT34. Did you see anyone using tobacco products, including cigarettes, cigars, pipes, or smokeless tobacco, or evidence that anyone had been using these products, on school grounds or at a school-sponsored event?

MT35. Have you seen a dentist in the past 12 months?

MT36. Did the dentist advise you not to smoke?

MT37. When the dentist advised you to quit smoking, did he suggest that you:

Use a patch, nicotine gum, nasal spray, inhaler or other form of nicotine replacement therapy?

Suggest cessation classes, programs, or counseling?

Provide you with brochures, books or videos to help you quit on your own?

Recommend that you call a toll-free cessation QuitLine?

MT38. For how many days in the past 30 days was your physical health not good?

MT39. For how many days in the past 30 days was your mental health not good?

MT40. For how many days in the past 30 days did poor physical or mental health keep you from doing your usual activities?